G STREET INTEGRATED HEALTH
SLIDING SCALE FEE APPLICATION

Please Read: The Sliding Scale Application is intended for those who **DO NOT** have health insurance coverage or are underinsured (high deductible plans)

1. You are required to submit documentation of your household's gross annual income in order to be considered for the sliding scale program.
2. It will take approximately 5 business days after receipt of your completed sliding scale application to process your application and update our system.
3. You will be notified by telephone regarding your sliding scale program status
4. If approved, your sliding scale application will automatically expire on June 1st of each year, and you must re-qualify with updated proof of income.
5. The sliding scale discount is applicable to services provided by G Street Integrated Health
6. You must notify the receptionist of your approved sliding scale discount *at the time of payment*. The sliding scale discount will not be applied to past visits or to billing statements.
7. All charges must be paid the day they are incurred. If you do not pay at the time of service, your discount *cannot be applied* and you will be responsible for the full price of services rendered.

You may qualify for our sliding scale program if your household income is below one of the following income levels <200% of the 2024 National Poverty Guidelines:

One Person Household	$30,132	Five Person Household	$73,164
Two Person Household	$40,884	Six Person Household	$83,940
Three Person Household	$51,660	Seven Person Household	$94,692
Four Person Household	$62,412	Eight Person Household	$105,444

9+ If more than 8 in the household/family add $5,380 per additional person

Family Size: Includes all individuals in the household who are related by blood, marriage, adoption, or foster care, including the head of household and dependent children.

Income Definition: Calculated based on gross annual income before taxes. The income should be less than 200% of the national poverty guidelines for the corresponding family size.

1. Sliding Scale Application Guidelines:

Use a black or blue ballpoint pen. Your completed application must include:

[ ] Age & Social Security Numbers for all household members.
[ ] Signature with date
[ ] Proof of Income (for each household member over 18 years old & current for the application year). Please provide one of the following:

- Current W-2 form(s) from all Employers
- Current tax return (must include completed signature & date page of return)

- Current Statement of Monthly Payment from SSI (Social Security), DHS (Food Stamps), Unemployment
- 3 months of recent employment pay stubs

(See Reverse Side for Application and submission instructions)

2. Please Print:

Applicant's Name:_____

Household Address:_____

Household Income:_____

Are you employed? [ ] Yes [ ]No If yes, by whom?
_____
Do you have sources of income of financial support other than employment? [ ] Yes [ ] No
If yes, please list *and* attach corresponding proof of income.

Including yourself, please circle the total number of people living in your household:
1 2 3 4 5 6 7 8+

Please complete the required fields below for each person living in your household, starting with yourself:
Note: If you do not fill out every field, your application will be returned to you to complete.

Full Name	**Birthdate**	**Relation**
1._____	_____	__Self___
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____

3. Please Sign:

I certify this information to be a true and accurate account of my household and financial status at this time. I have read and agree to the sliding scale program provisions.

Applicant Signature:_____

Date:_____

Please submit or mail your completed application directly to:

G Street Integrated Health
Attn: Sliding Fee Scale Application
1435 G Street
Springfield, OR 97477

CLINIC USE ONLY

Verification Checklist

Verification Checklist	Yes	No
ID – address verification – ODL, utility bill		
Income – prior year tax return, three most recent pay stubs, other		
Date received:		
Processed by:		
Approval date:		
Date patient notified:		
Annual expiration:		